Medicaid Information Bulletin
for the
Non-Traditional Medicaid Plan

July 2003

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BULLETINS BY TYPE OF SERVICE

NON-TRADITIONAL MEDICAID PLAN MANUAL ON-LINE

When the NTMP Section is updated, the on-line version will also be updated. Providers can obtain a copy of an updated page, or the entire NTMP Section, by using the web site or by contacting Medicaid Information. When pages are updated, the revision date appears at the top of the page. The change is typically marked in the left margin of the page with a vertical line.

The Medicaid Provider's web site http://health.utah.gov/medicaid/html/provider.html has a link to the NTMP Section. The link is a heading in bold print. Or go directly to www.health.state.ut.us/medicaid/ntmp.pdf

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03 - 60 Hearing Services and Speech Therapy: Chapters 2 - 6 and 2 - 7

Beginning July 1, 2003, audiology evaluations for hearing losses are covered one per calendar year. Use Code V5010, Assessment for hearing aid. Hearing aids are covered if the hearing loss is the result of a congenital defect. Hearing aids require prior authorization.

Beginning July 1, 2003, speech and language services are covered if therapy is to restore speech loss or to correct impairment, if the required services are due to an injury, illness, or congenital defect. Services require prior authorization.

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World Wide Web: http://health.utah.gov/medicaid/

Medicaid Information
- Salt Lake City area, call 538-6155.
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.
- From other states, call 1-801-538-6155.

Requesting a Medicaid publication?
Send a Publication Request Form.
- by FAX: 1-801-536-0476
- by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106

03 - 61 Other HIPPA Related Y Code Changes Effective October 1, 2003

The following Y codes will be closed when programming is completed; the listed replacement HCPCS will be reimbursed at the same rate and conditions as the Y code or the CPT code.

Ycode
Y7600 Anesthesia sedation for imaging replaced by CPT sedation codes 99141or 99142
Y8880 Dietitian Special HC needs child by Telehealth replaced by S9470 with GT modifier and TF modifier
Y9300 RN Telehealth homecare 15 minute(1unit) replaced by T1002 w GT modifier
Y9301 RN Telehealth homecare 30 minutes(2unit) replaced by T1002 w GT modifier
Y9302 Dietician Counseling Telehealth Homecare replaced by S9470 w GT modifier and TG modifier
Y9590 Nutrition Assessment & Care Plan replaced by 97802 in 15 minute increments (4 units) limited to 4 units or one hour per year
Y9595 Nutritional Therapy replaced by 97803 in 15 minute increments (4 units) limited to four units per date of service
Y0944 Diabetes Self Management Training replaced by S9455
Y9007 Directly observed TB therapy office replaced by T1502
Y9008 Outreach TB DOT replaced by H0033
Y0458 San Juan Home Health Differiental—The Modifier TN must be placed on the first line of the claim along with the appropriate home health code.

Y codes which have been closed because there was not evidence of recent use, the code is no longer needed and/or there is not an appropriate HCPCS code to adapt for the purpose of the code.
Y1350 CRNA supplies -office anesthesia
Y4681 MMR vaccine last
Y4773 HepatitisB vaccine
Y4797 HIB/Haemophilus influenza
Y5410 Physician HIV/AIDS case management
Y6666 Home Visit TB patient
Y6700 Primary care South Davis
Y6705 Initial consult South Davis specialist
Y6710 Followup consult South Davis
Y7777 Disease oriented CM
Y9006 TB targeted CM
Y9240 TB unit daily rate
Y9550 Outpatient Rehabilitation Day care

The Y code conversions required under HIPPA and mentioned above were added to the physicians or home health manual With the HIPPA changes, the telehealth modifier TR for the presenting provider has been discontinued. The modifier for telehealth data–TD has been discontinued and replaced with modifier GQ. ○

03 - 62 CPT Code Changes

CPT Codes Not Covered

Medicaid does not cover the CPT codes listed below. The Medicaid list states these codes are "NOT A BENEFIT." Descriptors in the list below are abbreviated.
10040 Acne Surgery (marsupialization, opening removal multiple milia, cysts, comedones, pustules)
11201 Removal skin tag ... each additional ten lesions
90657 Influenza vaccine, split, 6-35 months (covered in vaccine for children program)

CPT Codes Requiring Prior Authorization

The CPT codes listed below are covered only with prior authorization, either written or telephone as indicated. Criteria are stated on the list dated April 2003.

Telephone Prior Approval Required for Codes Listed below

19357 Breast Reconstruction with tissue expander

Codes Limited by Age

The following CPT Codes are limited by age:
90633 Hepatitis A vaccine Ped/Adolescent, 2 dose, IM
90634 Hepatitis A vaccine Ped/Adolescent, 3 dose, IM
90700 Diphtheria tetanus toxoid (DTAP), IM

CPT Code Requiring Documentation with Claim

An unlisted CPT code and the following codes do not require prior authorization. However, it the provider must attach documentation to the claim for staff review.
11200 Removal of skin tags

Coding issue discrepancy noted in the April 2003 MIB

The covered MRI code procedures 72141 through 72158 were discussed as requiring writtten prior approval under criteria 40B and as requiring documentation with the claim. The covered MRI procedure codes 72141 through 72158 require written prior approval under Criteria 40B. ○

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03 - 63 CPT Codes With Other Criteria

Two other groups of CPT codes do not require prior authorization, but are subject to new Medicaid criteria.
Benign Lesions: The code 11200–Skin Tag removal was added to the Benign lesion criteria #34. Documentation will be required for review supporting medical necessity and that the purpose of the procedure was not cosmetic.

New Criteria or Changes to Existing Criteria

Vagal Neurostimulator Criteria#32 A, the criterion were revised to require evidence epilepsy is refractive to four drugs, a statement of device benefit from the neurologist, and review of required tests needed with medical record documentation.

Benign Lesion Criteria # 34, The code 11200 skin tag removal will now require submission of documentation supporting that the service is not cosmetic. The additional skin tag lesion code 11201 has been closed.

Medical and Surgical Procedures List and Hospital Surgical Procedures Some inconsistencies were identified between the CPT list and the Hospital Surgical Procedure list. Both lists have been corrected.

List of Noncovered NonTraditional Medicaid Services

A list of Nontraditional Medicaid Non-covered Procedures has been provided in the manual. This list includes services that are included in Medicaid but are not included within the NonTraditional Medicaid program. This list, "NTM - CPT Code List", is used in addition to the Medicaid Medical and Surgical Procedures List

Physician Manual, SECTION 2, Addendum

Under limitations section M.. Specimen collection. When the codes 85014, 85610, 83036 and 86318 with modifier QW, the code G0001 is mutually exclusive or not covered for blood tests obtained by fingerstick

Under limitations N. Some regional or local anesthesia procedures don't require monitoring according to Medicare and may be completed by the surgeon. An example of this type of service is code 01995. Regional anesthesia provide by the surgeon is included within the global surgical fee and is not separately reimbursable. When monitoring is required

during regional or local anesthesia, services are payable to the anesthesiologist. ○

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03 - 64 Vaccination Issues in Adults: Chapter 2 - 16, Preventive Services and Health Education

There is concern related to the frequency and conditions of use of some vaccines in adults. This information is provided to update providers on adult immunization based on CDC guidelines.

Hepatitis: Hepatitis A vaccine is typically provided initially and then the second dose six months later. Hepatitis B has a three dose requirement so that after the initial dose, one is given one to two months later, and the third is given at least six months but never more than twelve months from the first vaccine. Data warehouse review of vaccine administration over the last two years indicated that pediatric/adolescent hepatitis A and hepatitis B vaccines have been provided to patients more than 19 years of age. In some cases an adult dose was provided one month to two months later. Documentation may be required to explain why a pediatric vaccine is administered to an adult.There is a new vaccine "Twinex" which includes an adult formula of hepatitis A and Hepatitis B. After the initial vaccine, one is given at one to two months later and the third vaccination is given six months from the first. The efficacy of these vaccines when mixed between the combination and the single versions have just been reviewed by the Division of Viral Hepatitis at CDC.Dr. William Atkinson, CDC, provides the following information, "If the first immunization is the "Twinrix," the hepatitis B portion counts, but the hepatitis A portion does not count. Followup with two hepatitis B vaccinations separated by at least two months and two doses of hepatitis A vaccine separated by at least six months. If two doses of "Twinrix" are given, the schedule may be completed with one dose of "Twinrix," or one does of adult hepatitis A vaccine and one dose of adult hepatitis B vaccine on the appropriate schedule. If one dose of adult hepatitis A and hepatitis B, the vaccination may be completed with two doses of "Twinrix," or one dose of hepatitis A vaccine and two doses of hepatitis B vaccine on the appropriate schedule."

Influenza: A second Influenza vaccination has been provided one week to two months from the first vaccination. Adults should receive only one influenza vaccine per influenza season. Should conditions occur where the patient receives one influenza vaccination in September requires a second vaccination, documentation for medical necessity may be required. Payment for additional doses given closer than four months apart will be denied in the future.

Pneumovax: A second pneumovax vaccination has been given two weeks to two months from the first. The Centers for Disease Control and Prevention states that in most cases one dose of pneumovax is sufficient. If the first dose was provided prior to age 65, a second dose may be indicated. The pneumovax vaccine **must be separated by more than five years.** When given sooner than five years, there are adverse reactions which may occur from this vaccine.

Tetanus/Diphtheria: A Tetanus Diphtheria (Td) booster should be given every ten years. Since diphtheria has resurfaced in Europe, the combination vaccine should be provided. In the event of a deep dirty wound the tetanus toxoid should be repeated if the booster was more than five years ago. For updates on adult vaccination visit the Centers for Disease Control and Prevention web site at http://www.cdc.gov/nip/recs/adult-schedule.pdf ○